Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 18, 2014	2014_248214_0006	H-000152-14	Resident Quality Inspection

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6

Long-Term Care Home/Foyer de soins de longue durée

ORCHARD TERRACE CARE CENTRE
199 GLOVER ROAD, STONEY CREEK, ON, L8E-5J2

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

CATHY FEDIASH (214), CAROL POLCZ (156), GILLIAN TRACEY (130), IRENE PASEL (510)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): February, 6, 7, 10, 11, 12 and 13, 2014.

Please note: This inspection was conducted simultaneously with the following complaint inspection: H-000747-13.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (DOC-A), Food Services Manager (FSM), Registered Dietician, dietary staff Program Manager, Business Coordinator, Environmental Services Manager (ESM), Nurse Clinician, Behavioural Support Staff, Resident Assessment Instrument (RAI) Coordinator, Residents' Council President, Registered staff, personal support workers, housekeeping staff, residents and families.

During the course of the inspection, the inspector(s) interviewed staff and residents, reviewed clinical records, relevant policies and procedures and observed care.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not ensure that there was a written plan of care for each resident that set out the planned care for the resident.

a) According to the clinical record, resident #811 had known responsive behaviours which included physical aggression towards co-residents, however, the plan of care did not identify strategies to manage physical aggression. The RAI Coordinator confirmed this information. [s. 6. (1) (a)]

2. The licensee did not ensure that the written plan of care for each resident provided clear directions to staff and others who provided direct care to the resident.

a) The plan of care for resident #001, indicated staff were to administer a topical medication every six hours when needed, however, the same physician's order also directed to administer the topical medication by mouth. Registered staff interviewed

confirmed the order did not provide clear directions to staff. [s. 6. (1) (c)]

3. The licensee did not ensure that the care set out in the plan of care was based on an assessment of the resident or needs and preferences of that resident

a) The plan of care for resident #814 indicated frequently incontinent of bladder and continent of bowels. Minimum Data Set (MDS) assessments completed on three specified dates in 2013, indicated continent of bowels and frequently incontinent of bladder. Staff interviewed confirmed the resident was incontinent of both bowel and bladder and had been since their admission in early 2013. Staff verified that the plan of care was not based on the actual needs of the resident. [s. 6. (2)]

4. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

a) According to the plan of care, resident #171 required a bed alarm for safety. It was observed on a specified date in 2014, that there was no bed alarm in place. Registered staff confirmed a bed alarm was not in place as specified in the plan. [s. 6. (7)]

5. The licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

a) The progress notes for resident #788 indicated the resident was transferred to the hospital on a specified date in 2013 and returned to the home with a prescribed system in place for the administration of a treatment and a dressing. The plan of care did not identify the signs and symptoms and potential for infection related to the system in place for administration of the treatment nor the care and treatment of the dressing. Registered staff confirmed the plan of care was not updated when the resident's care needs changed upon return from hospital.

b) A review of resident #805's written plan of care, indicated that the resident walked to and from the dining room. Interviews conducted with the Administrator, Acting Director of Care, Resident RAI Coordinator and personal support staff, confirmed that the resident no longer walks to the dining room, but used their wheelchair and that the written plan of care was not revised when the resident's care needs changed. (Please note: This evidence of non-compliance was found during Inspection

#2014_248214_0007). [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out the planned care for the resident, provides clear directions to staff and others who provide direct care to the resident, that the plan is based on an assessment and the preferences of that resident, that care set out in the plan is provided to the resident as specified in the plan and that the resident is reassessed and the plan of care is reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee did not ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

a) According to the bath records reviewed from November 1, 2013 to January 31, 2014, resident #815 received 8 out of a possible 24 baths during this time period. Interviews held with the resident and the frontline staff confirmed the resident was being offered and consistently receiving her desired number of baths, however, the care provided was not being consistently documented in the flow sheet records.

b) The clinical record for resident #788 indicated in a progress note dated on a specified date 2013 that the resident was "received from transfer unit in hospital", however, there was no documentation recorded prior to this note to indicate the date, time or reason for the hospital transfer. Another progress note dated on a specified date in 2013, indicated 911 was called and the resident was transferred to hospital a second time. There were no records found to indicate how long the resident was gone, whether or not the resident was admitted or when the resident returned from hospital. Registered staff confirmed this information.

c) According to the clinical record for resident #001, staff initiated "post fall vitals" on a specified date in 2013, related to an incident which had occurred the day before. Staff interviewed confirmed there was no documentation recorded related to any incident occurring on the specified date or any assessments conducted related to a fall.

d) Resident #001 passed away in the home on a specified date in 2013, staff confirmed there was no documentation recorded related to the time of death or any assessment's conducted at the time of death. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee did not ensure that all residents received fingernail care, including the cutting of fingernails.

a) Resident #815 was observed on two occasions in 2014 and noted to have some long finger nails measuring greater than 0.5 centimeters in length. The resident was interviewed and stated a desire to have their nails trimmed as this was not their desired length. The plan of care indicated the resident was to receive a bath/shower on Wednesdays and Saturdays and that nails were to be trimmed on those dates. According to bath records reviewed from November 1, 2013 to January 31,2014, nails were not trimmed during this time period. Staff interviewed confirmed the residents nails were too long and had not been trimmed as per their plan.

b) Resident #804 was observed on two occasions in 2014 and noted to have long, uneven fingernails. The resident was interviewed and stated they preferred their nails shorter. The plan of care indicated that staff were to ensure that nails were manicured on bath days. The bath records indicated the resident had not had their nails trimmed since October 29, 2013. Staff confirmed the nails were too long and that the records were accurate.

a) On a specified date in 2014, resident #803 was observed to have long, uneven fingernails. The resident stated that their nails were not at their preferred length. A review of the clinical records from November 23, 2013 to February 10, 2014, indicated nails had not been trimmed during this time period. Staff confirmed resident's nails were not trimmed. [s. 35. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home receives fingernail care, including the cutting of fingernails, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.

Findings/Faits saillants :

1. The licensee did not ensure that every resident received end-of-life care when required in a manner that was consistent with their needs.

a) Resident #001 had an end of life care plan put in place on a specified date in 2013. The progress notes were reviewed from August 1 to September 5, 2013 and indicated from August 8 -29, 2013, that the resident was agitated and/or restless. Progress notes indicated the resident's pain was not being effectively managed. Medications ordered by the physician, to be administered on an as needed basis, were not always given when the resident exhibited pain. The resident's agitation and restlessness did not subside until after the family requested a review of medications and the physician ordered analgesics to be given routinely. The resident passed away in the home on a specified date in 2013. Staff interviewed confirmed the resident's pain was not controlled from August 8 to 29, 2013. [s. 42.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident receives end-of-life care when required in a manner that is consistent with their needs, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee did not ensure that, for each resident demonstrating responsive behaviours, that actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

a) A review of resident #811's clinical record, identified that this resident was demonstrating responsive behaviours of physical aggression toward co-residents for a specified period of time. The home documented on a specified date in 2013, that the Responsive Behaviour Coordinator was notified of the responsive behaviours, however, the Behavioural Support Outreach Representative confirmed that they had not received a referral to assess this resident's responsive behaviours. Staff confirmed, the referral had never been made. [s. 53. (4) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, for each resident demonstrating responsive behaviours, that actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee did not ensure that there was a weight monitoring system to measure and record each resident's weight on admission and monthly thereafter.

a) Resident #787 did not have a weight taken or recorded for the months of August and December 2013, January and February 2014.

b) Resident #814 did not have a weight taken or recorded for the months of July, August and October, 2013.

c) Resident #772 did not have a weight taken or recorded for the month of January, 2014.

d) Resident #769 did not have a weight taken or recorded for the month of July, 2013.

d) Resident #784 did not have a weight taken or recorded for the month of December, 2013.

This information was confirmed by staff. [s. 68. (2) (e) (i)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a weight monitoring system to measure and record each resident's weight on admission and monthly thereafter, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee did not ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated: 1. A change of 5 per cent of body weight, or more, over one month. 2. A change of 7.5 per cent of body weight, or more, over three months. 3. A change of 10 per cent of body weight, or more, over 6 months. 4. Any other weight change that compromises the resident's health status.

a) The weight for resident #814 in November 2013, was noted to be 92.2 kilograms (kg). In December 2013, the resident's weight was 81.4 kg which represented a decrease in weight of 10.8 kg in one month (8.8% over one month). As confirmed by the registered staff and RAI Coordinator, a dietary referral was not initiated and the RD did not assess this residents' weight change for this time period.

b) The weight for resident #775 in December 2013, was noted to be 59.4 kg. Early in January 2014, the resident's weight was 56.3 kg which represented a decrease in weight of 3.1 kg in one month (9.5% over one month). As confirmed by the registered staff and RAI Coordinator, a dietary referral was not initiated and the RD did not assess this resident's weight change until January 29, 2014. The RAI coordinator indicated that expected time frame for follow up by the RD would be on next weekly visit. [s. 69. 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee did not ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area.

a) The home's discontinued controlled substances were stored in a locked room, inside a locked metal box, however the registered staff confirmed that the cupboard they were stored in did not have a locking mechanism. [s. 129. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance did not ensure that controlled substances were stored in a separate, double-locked stationary cupboard in a locked area, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee did not ensure that all staff participate in the implementation of the program.

a) On February 6 and 12, 2014, during the initial tour, roll on and stick deodorants, which were not labelled for individual resident use, were discovered on care carts in resident rooms and in the " SPA" room. Registered staff confirmed, that roll on and stick deodorants should not be stored in care carts unless labelled for individual resident use. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the infection prevention and control program, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that every resident was afforded privacy in treatment and in caring for his or her personal needs.

a) During observation of the noon hour medication administration pass on a specified date in 2014, it was observed that resident's #584, #761, and #793, received a medication by injection to their arm, in the presence of others.

b) On a specified date in 2014, resident #584 and #761, had not received privacy in treatment as they were observed receiving a medication by injection in the stomach in the hallway outside the dining room in the presence of others.

The Administrator confirmed that this was not an acceptable practice and did not afford the right to privacy. [s. 3. (1) 8.]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee did not ensure that the home was a safe and secure environment for its residents.

a) On February 6, 2014 at approximately 1030 hours, the "laundry room" door was found unlocked. This unlocked door provided access to an unlocked laundry chute. Staff confirmed the laundry room door should be locked at all times when not in use. [s. 5.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee did not ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put into place was complied with.

a) The home's policy, Falls Prevention Program, indicated that information was entered in the risk management section of Point Click Care(PCC) when a resident falls and that this report was used to track falls in the home on a monthly basis. A review of resident #171's clinical record indicated that the resident had fallen on four specified dates in 2014, however, a review of the resident's record, indicated risk management reports were not completed for falls which occurred on two of the four specified dates 2014. Registered staff confirmed that risk management reports should be completed for all falls as per policy. [s. 8. (1)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee did not ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The homes Abuse or Neglect Policy (index RCS P-10) indicated:
The Director of Nursing or Administrator immediately initiates an investigation to determine if the alleged reported abuse or neglect can be substantiated. The investigation must include but not be limited to interviewing the following:
a. The person(s) reporting the alleged abuse/neglect, and obtaining a written statement
b. The alleged victim(s) and obtaining written statement(s0
c. The alleged perpetrator(s) and written statements (implicated employee(s) is/are entitled to union representation
d. All witnesses and obtaining written statements .

a) On a specified date in 2013, the Administrator received a complaint from a family member related to bruising. The home submitted a critical incident report related to alleged abuse. Review of the complaint investigation file indicated the home did not obtain written statements from witnesses.

b) On a specified date in 2013, the Administrator received a second letter from another family outlining an event that indicated possible neglect of a resident. The home submitted a critical incident report related to alleged abuse. There was no evidence of an investigation related to this incident. The Administrator confirmed there was no documentation for this investigation. [s. 20. (1)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee did not ensure that a care conference of the interdisciplinary team providing a resident's care was held within six weeks following the resident's admission.

a) Resident #584 was admitted on a specified date in 2013 and as confirmed by registered staff and the activity director, did not have a six week care conference. [s. 27. (1) (a)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(c) a cleaning schedule for the food production, servery and dishwashing areas. O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee did not ensure that there was a cleaning schedule for the food production areas, servery areas, and dishwashing areas and that staff comply with this schedule.

a) On a specified date in 2014, the kitchen was found to be in need of a deep cleaning as the walls, floors, corners were found to be dirty. The pipes behind the stove area were layered with dust and the shelving in the kitchen area was soiled. As confirmed with the Food Services Manager, the kitchen area required a deep cleaning and the home did not have a deep cleaning schedule for the kitchen and food production areas. [s. 72. (7) (c)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee did not ensure that a documented record was kept in the home that included, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

a) On a specified date in 2013, a family member expressed concern to the Administrator with regards to identified bruising to resident #002. The Administrator confirmed the home did not maintain a record of the response to the complainant with regards to any action taken, follow up action required or the final resolution, if any.

b) On a specified date in 2013, the home received a written letter of complaint from the family of resident #001, related to an incident of possible neglect of the resident. The home could not provide a written record of the investigation or the written response provided to the complainant. [s. 101. (2)]

Issued on this 3rd day of March, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs